

Utilizing the Maslach Burnout Inventory to measure burnout in HIV/AIDS specialist community nurses: the implications for clinical supervision and support

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The concept of burnout among health care professionals involved in AIDS care has been well documented in hospital and hospice settings, but no empirical research has been conducted among practitioners working with AIDS patients in the community setting. This study used a burnout measurement tool, namely the Maslach Burnout Inventory (MBI), to measure the level and components of burnout in a sample of 47 community HIV/AIDS nurse specialists. The study also explored the under-researched relationship between different elements of the MBI. The main finding of the study was a high level of burnout among these practitioners, with over 50% of participants scoring as burnout 'cases'. There was no link between burnout and caseload and length of time in practice, and female respondents rated marginally higher with regard to the number of burnout cases. There was also a close relationship between the intensity and frequency scales on the MBI. The importance of utilizing both a supportive model of clinical supervision and also the development of less formal peer support systems is suggested as a way forward in addressing burnout prevention in this group of practitioners.

Key words: AIDS; burnout; clinical nurse specialists; community nursing; supervision

Introduction

A major trend in AIDS care in developed countries is the increase in home care for patients with HIV disease and AIDS. The two key factors that have precipitated this trend are changes in the structure of hospital care, which have seen an increasing emphasis on home care, and the rapid development of increasingly effective treatment for HIV disease, which has transformed the illness from a short, acute process requiring in-patient care to one that is more chronic in nature with periods of remission (Butterworth and Faugier, 1992; Brocklehurst *et al.*, 1994).

There is a large body of literature on the effects on staff of caring for HIV-positive clients in the hospital and hospice environment (Ross and Seeger, 1988; Drediger and Cox, 1991; Miller, 1995), and much of this work explores the relationship between AIDS care and burnout. Only a limited number of studies have explored the effects of AIDS care on practitioners working in the community/home care setting (Haviland *et al.*, 1996; Perreault *et al.*, 1996), and no research of this nature has been conducted in Europe.

In response to the changing environment of AIDS care, community nurses have increasingly become involved in caring for patients with HIV in the patients' own homes. The numbers of patients have been sufficiently low to enable the planning and delivery of care often to be provided by an individual practitioner, namely a community

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nurse with the title Clinical Nurse Specialist (HIV) (Hicken and Butterworth, 1995).

The aim of this study was to examine the extent and components of burnout morbidity within this population of practitioners, and to suggest measures for prevention.

Literature review

For this study, a literature review was performed using the CINAHL, MEDLINE and ASSIA CD-ROM databases. Additional literature was obtained from the abstracts listings for the International AIDS conferences 1992–96, and from the Abstract CD-ROM of the International Conferences on Home Care and Community Care for People with HIV/AIDS. The keywords used for searches were ‘burnout’, ‘AIDS/HIV’, ‘health care workers’, ‘nursing’, ‘community nursing’, ‘home care’ and ‘ambulatory nursing’.

Burnout

The term ‘burnout’ was first used in 1974 by Freudenburger, who observed symptoms of clinical fatigue and frustration caused by excessive demands being made on personal resources among staff working in clinics in the USA. Since then a number of definitions of the syndrome have been attempted, perhaps the most succinct being by Randolph *et al.* (1986:1): ‘burnout is the result of occupational stress that is continued over extended periods of time’. Miller (1995:2) describes burnout as ‘the end-stage consequence of a chronic process of frustration and deterioration in the individual worker exposed to unremitting stress in the workplace.’

Burnout in nursing practice

It is clear from the literature that the research on burnout in nursing has placed a heavy emphasis on hospital/hospice-based practice.

Nursing is a stressful occupation (Marshall, 1980; Harris 1989). The reasons for this are multifactorial and include work overload (Weinburg *et al.*, 1983; Shinn *et al.*, 1984; Constable and Russell, 1986), role conflicts (Stout and Posner, 1984; Sullivan, 1989; Rabinowitz *et al.*, 1996), dealing with human suffering, inadequate management and support (Hingley and Harris, 1986; Reed, 1988; McGrath *et al.*, 1989), personal problems, poor career structures and lack of training (Miller, 1995).

Vachon (1987), in a study exploring stress in hospice nurses found levels of stress only slightly below the levels recorded in those recently widowed. In addition, the effect of stress on attrition rates in nursing has been described by a number of authors (Cohen and Orlinsky, 1977; Shinn *et al.*, 1984; Miller, 1995).

Burnout in AIDS care

Studies of work stress and burnout in AIDS care routinely show moderate to high levels of morbidity. Work by Miller (1995), in a study comparing 100 oncology nurses and 103 hospital-based AIDS nurses in the UK, found high levels of stress and burnout factors in both populations. Respondents scored as ‘cases’ on psychiatric screening instruments (the Maslach Burnout Inventory and General Health Questionnaire) in 41% of cases, and 70% and 61% of respondents, respectively, scored as having moderate to high levels of emotional exhaustion and reduced levels of personal achievement using the Maslach Burnout Inventory.

Van Servellen and Leake (1994) found high levels of stress symptomology and emotional exhaustion in a sample of 153 American hospital nurses caring for AIDS patients. This study utilized the emotional exhaustion scale of the MBI and bivariate analysis of emotional exhaustion scores and personal and demographic variables from the population. The results included positive correlations between age, length of service and fear of contracting HIV with high emotional exhaustion scores on the MBI.

Several studies have identified both the contagious nature of the infection and the link with sexuality as being a source of stress. Dunkel and Hatfield (1986) and Dreidger and Cox (1991) have described fear of infection as a significant stress in AIDS care nurses. Homophobia has been reported in studies by Ross and Seeger (1988) and Strathdee *et al.* (1991).

Masterson-Allen *et al.* (1985) have described the effect of the relatively young age of patients with AIDS, and the effect of continual exposure to deaths in contemporary age groups, as a significant source of stress among AIDS nurses.

The contributory effect of nurse–patient relationship factors on burnout in AIDS care has been described in several studies. Visintini *et al.* (1995), in a study of 410 Italian AIDS nurses,

found that a tendency to over-identify with clients was predictive of burnout, and that development of an empathic but controlled relationship was protective.

An additional aspect of the over-identification with patients is the impact of client death on nursing staff. Miller (1995) described high levels of emotional exhaustion on the Maslach Burnout Inventory that correlated with experience of the death of clients. This study compared UK AIDS hospital nurses ($n = 100$) and oncology nurses ($n = 103$) and found that even though the oncology nurses experienced death more frequently, it had less of an emotional impact.

Community nursing and burnout

Although research studies exist that are community based, in contrast to the literature on burnout among hospital and hospice nurses, there is a significant lack of research in the arena of community nursing.

Palsson *et al.* (1996), in a quasi-experimental study of Swedish community nurses, utilized burnout measures, personality scales and empathy construct rating scales to explore the relationship between clinical supervision and burnout. The numbers in this study were small ($n = 21$), and no significant difference in burnout was reported between a control group and the study population in relation to access to clinical supervision. These findings are not supported by those of many larger studies (Randolph *et al.*, 1986; Bolle, 1988; Hare *et al.*, 1988) which identify a link between burnout and lack of access to supervision.

In a larger comparative study, Jansen *et al.* (1996) explored the relationship between job and personality characteristics and burnout amongst community nurses and community nursing auxiliaries in The Netherlands. A total of 402 community nurses/auxiliaries completed the Maslach Burnout Inventory and an organisational stress questionnaire. Low to moderate levels of burnout were reported, with the registered nurses scoring higher on burnout scales than the auxiliaries.

Faura *et al.* (1995), in a comparative study in Spain, reported higher levels of burnout (utilizing the MBI) in hospital-based nurses than in community nurses in an investigation involving 237 nurses. The researchers argue that hospital-based factors such as high workload and stress are significant in predisposing to burnout, and that these

factors are less marked in community settings. Although this is an interesting study, its generalizability is limited due to the differences between community nursing in Spain and that in northern European countries, where community nurses have more clinical responsibility and care for patients with more acute illness at home.

The absence of clinical supervision and the presence of heavy workloads and traumatic experiences (terminal illness/death) were linked to the presence of stress in a survey of Canadian home care nurses by Walcott-McQuigg and Ervin (1992), in which a survey questionnaire was completed by 67 community nurses. Although this study described stressors, the failure to use a recognized burnout measurement tool limited the findings somewhat.

Burnout in AIDS care among community/home care nurses

This is an under-researched area. The vast majority of research on stress and burnout in AIDS care has been in the hospital arena. This is not surprising given the trends of HIV disease epidemiology, morbidity and treatment. It is only relatively recently that patients with HIV disease have entered the home care arena in significant numbers. Consequently, research on nurses involved in AIDS care in the home setting is under-represented in the literature, and confined to the USA.

Haviland *et al.* (1996) used the Maslach Burnout Inventory (MBI) and interviews to assess levels of burnout in a sample of 86 community-based AIDS care workers in the USA. This sample included some nurses but also voluntary and clerical staff. Low to moderate levels of burnout were described, but the study was not designed to compare burnout levels for the different types of staff, thus making it difficult to assess burnout among the nurses in the study.

Perreault *et al.* (1996), in a qualitative study that involved interviewing 31 community AIDS care staff in a sample that again included nurses but also volunteers, described the effects of multiple deaths and close identification with clients as being significant stressors in AIDS care, although the lack of a burnout measurement instrument and the failure to distinguish nurses within the population limit the value of the study to understanding of the community nurse experience.

Clearly this is an under-researched area, parti-

cularly in the UK, and this under-representation provides the rationale for this study.

Methodology

A descriptive exploratory study was designed with the aim of utilizing the Maslach Burnout Inventory to measure burnout in HIV/AIDS specialist community nurses and to explore the implications for clinical supervision and support.

The objectives of the study were as follows:

- to measure burnout morbidity within the sample;
- to measure the relationships between burnout frequency and intensity scores on the Maslach Burnout Inventory;
- to determine the correlations between population characteristics and burnout subscale scores (frequency and intensity) on the Maslach Burnout Inventory.

Measurement of burnout

Burnout has been characterized by a number of authors (Edelwich and Brodsky, 1980; Maslach and Jackson, 1982; Miller *et al.*, 1995) as being composed of certain elements that can be developed into measurement tools for research purposes. Numerous studies involving health care professionals, particularly social workers and nurses, have been conducted over the last 20 years.

Despite the complexities of factors that predispose to the end-stage 'state' of burnout, the syndrome itself has been most successfully described in the model developed by Maslach and Jackson (1982), which identifies burnout as having three central constructs:

- emotional exhaustion – having no capacity left to offer psychological support to others;
- depersonalization – a negative and callous attitude to colleagues and patients;
- a reduced sense of personal achievement – playing down or disregarding positive job performance and past achievements.

These three constructs form the basis of the most frequently used quantitative burnout measurement tool, namely the Maslach Burnout Inventory (MBI).

The MBI was developed from extensive research involving 1025 'human services' personnel,

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including nursing and medical staff. It consists of a 22-item scale, of which nine items comprise the emotional exhaustion subscale, eight items comprise the personal accomplishment subscale, and five items comprise the depersonalization subscale. Each subscale contains a range of statements, examples of which are listed in Box 1.

Box 1 Examples of Maslach Burnout Inventory (MBI) subscale items

Emotional exhaustion (nine items in total)

I feel emotionally drained by my work

I feel burned out by my work

Working with people all day is a real strain for me

Personal accomplishment (eight items in total)

I deal very effectively with the problems of my recipients

I feel I am positively influencing other people's lives through my work

I feel exhilarated after working closely with my recipients

Depersonalization (five items in total)

I feel I treat some recipients as if they were impersonal objects

I've become more callous towards people since I took this job

I don't really care what happens to some recipients

Respondents rate each item on a seven-point (0–7) ordinal scale for how frequently they experience the feeling (frequency), and a six point (0–6) ordinal scale that measures how strongly they rated the emotion (intensity). Mean scores for frequency and intensity are then calculated, and respondents are classified as high, moderate or low burnout cases on the respective constructs. Scores relating to 'caseness' are listed in Box 2. A 'case' in this instance refers to a respondent who scores at a certain level on each of the burnout constructs, and is

therefore deemed to show moderate or high levels of burnout.

Box 2 Burnout case scores: subscales of the Maslach Burnout Inventory (MBI)

Emotional exhaustion

High burnout score: ≥ 27

Moderate burnout score: 17–26

Low burnout score: 0–16

Personal accomplishment

High burnout score: 0–31

Moderate burnout score: 32–38

Low burnout score: ≥ 39

Depersonalization

High burnout score: ≥ 13

Moderate burnout score: 7–12

Low burnout score: 0–6

*Scores above relate to low, moderate and high scores for burnout on the Maslach Burnout Inventory. Whereas *high* scores on the emotional exhaustion and depersonalization subscales score as *high burnout*, it must be noted that conversely *low* scores mean a *high burnout* score on the personal accomplishment scale.

Evidence of burnout is considered to be particularly related to high scores on the emotional exhaustion subscale combined with low scores on the personal accomplishment subscale. However, individual ‘case’ scores on subscales are regarded as important markers of burnout.

The MBI can therefore measure burnout in two ways, first by frequency of experience secondly by intensity of experience. In order to understand better burnout in a population, and to explore the issues for support and supervision, determining the relationship between these two elements could be important. For example, does burnout morbidity as recorded by the frequency scale correlate with that of the intensity scale? Is burnout related solely to

the significance of infrequent but highly emotive aspects of practice, or is it influenced by the frequency with which those events occur over time?

The MBI has become the main measurement tool for burnout in health care professionals, and its reliability and validity have been extensively explored (Schaufeli *et al.*, 1993). However, there has been little research on the relationships between the two rating scales (intensity and frequency) within the subscales of the inventory, with emphasis having been placed on burnout frequency scores alone in the majority of studies.

Data collection

Data collection took place in two stages. In stage one, during 1997, a purposive sample of 36 HIV clinical nurse specialists working in community settings was sent the Maslach Burnout Inventory and a participant specification questionnaire. This initial sample of practitioners was drawn from an HIV clinical interest group that covered the north of England. In stage two (1997–98), through nominated sampling a further 25 questionnaires were sent to additional community specialist nurses working in AIDS care who were not included in stage one. No figures exist for the number of HIV community nurse specialists working in this geographical area. However, anecdotal reports suggest that this study accounted for approximately 70% of clinical nurse specialists in the north of England.

All of the questionnaires were anonymous, and respondents were assured that no individuals or geographical locations would be identified. The study was conducted with the permission and support of the HIV/AIDS clinical nurse specialist forum. An initial letter which was sent to potential respondents clearly set out the aims and the confidential nature of the study.

In stage one, 32 completed questionnaires were returned, and in stage two 15 questionnaires were returned, giving an overall response rate of 77% ($n = 47$, out of a possible sample size of 61 subjects).

Data analysis

Descriptive statistics were applied to the data to describe age, gender, case-load, length of time in AIDS care, and individual or team working characteristics.

Data were analysed both to explore levels of

burnout morbidity and to examine the relationships between subscale scores of frequency and intensity on the MBI. This was done using the subscale score criteria for burnout outlined in Box 2. For bivariate analysis, moderate and high case scores on subscales were combined to give one figure for burnout (both frequency and intensity). In addition, MBI frequency and intensity subscale scores and their relationship to population characteristics of age, gender, case-load and whether individuals were working alone or as part of a team were explored.

The Kendall tau correlation coefficient was used to analyse the statistical correlations between data. This was chosen as it is appropriate for small data sets involving ordinal data (Babbie and Halley, 1995). The data were analysed by means of SPSS v.8. Two-tailed tests for significance were utilized, given the lack of previous data on the relationship of the variables concerned.

Results

In total, 85% ($n = 39$) of respondents were female and 15% were male ($n = 8$). A significant proportion (55%; $n = 26$) had been working in AIDS care for longer than 3 years, with 36% ($n = 17$) involved in AIDS care for between 1 and 3 years. As only 8.4% ($n = 4$) of respondents reporting working in AIDS care for 1 year or less, the sample can be said to consist of relatively experienced practitioners in this field.

Of the 47 respondents, 21% ($n = 9$) identified themselves as working in a team, whilst 79% ($n = 38$) worked alone.

Case-load varied, but 59.4% ($n = 27$) of respondents reported over 25 clients per year, 29.6% ($n = 13$) reported 11–20 clients per year and 10.6% ($n = 7$) of respondents reported 10 or less clients per year. This sample therefore contains a significant number of practitioners within the higher range of case-loads.

Burnout morbidity was clearly prevalent within this population. On intensity scores for subscales of the MBI, a mean rate of 46% ($n = 21$) scored as cases, and on frequency scores for subscales of the MBI a mean rate of 54% ($n = 25$) scored as cases. Scores for each subscale of the intensity and frequency scales are shown in Table 1.

Table 1 Burnout morbidity (scored as cases) within MBI subscales: frequency and intensity ($n = 47$)

	Intensity scores	Frequency scores
Emotional exhaustion	23 (48.9%)	40 (85.1%)
Personal accomplishment	22 (46.8%)	35 (74.4%)
Depersonalization	20 (42.5%)	2 (4.2%)

Relationship between intensity and frequency ratings

When assessing burnout case morbidity using frequency scores on the MBI, there were higher levels of burnout on the emotional exhaustion (85%; $n = 39$) and personal accomplishment (74.4%; $n = 34$) subscales than for intensity scores (48.9%; $n = 23$ and 46.8%; $n = 21$, respectively).

There were strong correlations between scores on both intensity and frequency ratings on the MBI, demonstrating that although some respondents rated intensity and frequency differently, there was a relationship between scores on the frequency scale and scores on the intensity scale. Kendall tau correlation coefficients for intensity and frequency score showed statistically significant correlations – for example, emotional exhaustion scores ($r = 0.63$, $P < 0.05$), personal accomplishment scores ($r = 0.66$, $P < 0.05$) and depersonalization scores ($r = 0.71$, $P < 0.05$). There was no evidence of high-frequency scores occurring with correspondingly low-intensity scores, or vice versa, indicating a link between the two ratings.

In addition, high and moderate burnout scores on the emotional exhaustion subscale correlated with burnout scores on the personal accomplishment subscale ($r = 0.78$, $P < 0.05$).

The relationship between scores on the emotional exhaustion or personal accomplishment subscales and the depersonalization subscale was not statistically significant ($r = 0.0085$).

Tables 2 and 3 show the relationship of the factors age, gender, case-load, teamworking and length of time in AIDS care with MBI intensity and frequency subscale scores. Only gender was highlighted as being significantly related to scores on the emotional exhaustion and personal accomplishment subscales. Female respondents were more likely to score as cases on these two subscales than male respondents. However, this

Table 2 Kendall tau correlation coefficients for MBI subscale scores ($n = 47$)

	Depersonalization frequency	Depersonalization intensity	Emotional exhaustion frequency	Emotional exhaustion intensity	Personal accomplishment frequency	Personal accomplishment intensity
Age	0.0552	0.0964	0.0416	0.0398	0.0777	0.0065
Gender	0.0634	0.0161	0.01504*	0.2637*	-0.3166*	-0.2807*
Case-load	-0.0968	-0.0161	0.0899	0.0471	-0.0240	-0.0501
Teamworking	-0.0947	-0.0398	0.0170	-0.0497	-0.1062	0.0717
Time in AIDS care	0.0286	0.0827	0.0674	0.0011	-0.0078	-0.0514

Table 3 Mean MBI subscale scores: frequency and intensity scores ($n = 47$)

	Mean value	Standard deviation
Emotional exhaustion (intensity)	31.43	12.92
Emotional exhaustion (frequency)	19.17	11.85
Depersonalization (intensity)	2.83	2.13
Depersonalization (frequency)	6.09	5.24
Personal accomplishment (intensity)	30.63	8.34
Personal accomplishment (frequency)	38.23	9.83

was only a weak relationship (0.15 EEf, 0.26 EEi; $P < 0.05$ and PAf -0.31, PAi -0.28; $P < 0.05$). No other correlations with sample characteristics were identified.

Discussion

Several findings emerge from this study. First, there is a high proportion of burnout morbidity within the sample, and secondly, there is a clear link between the ratings of frequency and intensity on all three constructs of the Maslach Burnout Inventory.

In terms of burnout predictors, it was interesting to note that there was no correlation for length of time spent working in AIDS care, which conflicts with the findings of research in other areas of care, where there is a relationship with burnout development over time (Miller, 1995). It is important to recognize that in AIDS care there may be a higher propensity to burnout signs after a relatively short period of time, and the factors associated with this should form the basis of further research.

As in other studies (Maslach and Jackson, 1982; Miller, 1995), the respondents demonstrated characteristic features of burnout, and the case scores on

the emotional exhaustion subscale correlated closely with personal accomplishment scores, indicating that similarities exist between this group of practitioners and hospital/hospice-based staff with regard to burnout characteristics.

However, the low scores on the depersonalization subscale are interesting, and do not relate to the general picture of burnout in other populations, which tend to score higher on this subscale. One possible explanation is that in this client group an over-involved relationship may precipitate burnout. This is another area that merits further study.

As with length of time spent working in AIDS care, there was no correlation with case-load and burnout, and again this finding does not reflect the results reported in the literature in other fields of practice (Vachon, 1987). This finding should make the reader guard against the assumption that low case-load is necessarily protective of burnout in this population. Burnout prevention strategies are important for all practitioners in this area of practice, irrespective of case-load or length of time in practice.

The weak but significant correlation between gender and burnout does not reflect the findings of other research on burnout in AIDS care (Miller,

1995; Visintini *et al.*, 1995), and this is an issue that warrants further research.

The correlations between frequency and intensity scores on the MBI demonstrate the relationship between the intensity of feelings experienced and the frequency with which they are experienced. The lack of anomalies in the two rating scales adds to the evidence which suggests that the Maslach Burnout Inventory is a valid and reliable tool. However, it would be worth noting that burnout research, when using the MBI, mainly concentrates on the frequency scales, and that greater use of the intensity scale would add to the richness of the data.

Support and supervision

Burnout is clearly a feature of this group of practitioners, and it has been linked to sickness, absenteeism and work-force attrition (Freudenburger, 1974; Randolph *et al.*, 1986; Miller, 1995). Therefore burnout prevention strategies are essential for vulnerable populations.

One possible way forward is the use of clinical supervision as a method of burnout prevention. Butterworth and Faugier (1992) have described clinical supervision as 'an exchange between two practising professionals to enable the development of professional skills', and they regard supervision as a formative and developmental process. The concepts that underpin clinical supervision (e.g., that it is an exchange between two practising professionals) are important if clinical supervision is to address burnout. A managerial, authoritative concept of supervision could have a limited role to play in burnout reduction if it did not embrace a supportive ethos.

Proctor (1991) has provided an appropriate model that incorporates a more supportive/developmental approach within supervision. For Proctor, supervision consists of the following three key tasks:

- formative tasks – the educative process of developing skills, teaching new methods and insights;
- restorative tasks – supportive help for professionals to enable them to deal with feelings that arise from working with people in distress;
- normative tasks – the managerial and quality control aspects of professional practice, designed to monitor and promote standards of care and ethics.

It would seem that the first two elements of this model in particular would be beneficial in burnout protection. Assisting practitioners in developing coping skills in relation to stress at work has been found to be helpful in reducing burnout (Riordan and Saltzer, 1992; Wade and Simon, 1993; Rabinowitz *et al.*, 1996), as has the provision of a mechanism for staff to express concerns and anxieties linked to practice (Randolph *et al.*, 1986; Miller, 1995). The opportunity to discuss issues with another professional would be particularly important for community practitioners, as they are more isolated and lacking in colleague support compared to hospital- and hospice-based practitioners.

A further point for discussion would be, given the skills required to utilize Proctor's model effectively, who would be the most appropriate person to perform clinical supervision. Discussion of the emotive elements of stressful situations and feelings of distress may well not be appropriate within a managerial relationship.

Although clinical supervision has its place in burnout prevention, more informal and less structured forms of support can also be helpful. There is ample evidence that informal support from colleagues can be helpful in reducing burnout (Wade and Simon, 1993; Rabinowitz *et al.*, 1996), either through the establishment of supportive relationships with other professionals working in the same area of practice, or by forming support groups of practitioners. These types of measures are valuable in that practitioners are able to discuss issues with colleagues whom they feel understand their area of practice.

The development of support groups can also enable practitioners to share examples of good practice and to discuss positive aspects of their role. There is evidence that such sharing can enhance self-esteem and strengthen positive aspects of practice in a way that may protect against burnout (Riordan and Saltzer, 1992; Rabinowitz *et al.*, 1996), and mechanisms to improve a sense of personal achievement within practice can impact upon the incidence of burnout.

As highlighted previously, peer support for relatively isolated community practitioners is a potentially valuable strategy for reducing occupational stress and thereby protecting against burnout. Perhaps a type of 'buddying' system of practitioners in similar fields of practice could be a way forward.

Limitations to the study

This study utilized a small sample, and the statistical results should therefore be interpreted with some caution. However, given the small number of community nurses employed as HIV clinical specialists, this was unavoidable. The use of a number of interviews would have helped to add depth to the findings, but given the geographical distances involved this was problematic, although it could form the basis for further research.

As with any questionnaire survey, the researcher is aware of the issue of nonresponse. Although in this study the response rates were good, it is not known whether nonresponders would demonstrate higher or lower levels of burnout than those who did complete questionnaires.

Conclusions

This is the first time burnout has been measured in any community nursing population in the UK, and it represents one of very few such studies conducted internationally. The focus on HIV specialists should not detract from the possibility of similar findings being obtained in other areas of community nursing practice. However, it must be noted that the relatively small sample size is a limiting factor with regard to generalizability.

There is significant burnout morbidity within this population. Both frequency and intensity constructs of the Maslach Burnout Inventory described burnout cases in a high percentage of the practitioners in the study. Clearly this poses potential mental health risks to these practitioners, and it also creates the potential problems of attrition and absenteeism in a specialized field of practice.

Both formal strategies for preventing burnout, in particular clinical supervision, and the development of less formal and structured forms of support, are important issues for the future with regard to this group of practitioners.

A number of potential areas for further research are highlighted by this study, particularly the effect of staff gender on burnout within AIDS care, and also the occurrence of burnout in practitioners who are relatively new to the AIDS care environment. Appropriate supervision and support strategies for com-

munity nurses working in AIDS care are essential, and examples of good practice are required, particularly empirically based studies that evaluate different models of supervision and varying types of less formal support in terms of their effect on protection against burnout.

Box 3 Key points

- Burnout is most often measured with the Maslach Burnout Inventory
- Burnout is poorly researched among community nurse populations
- Burnout research among hospital/hospice-based nurses describes high levels of burnout
- More community nurse involvement in AIDS care necessitates burnout research among this group of practitioners
- High levels of burnout have been found in community AIDS care specialists
- There is a link between frequency and intensity scores on the MBI
- There is no link between burnout cases and case-load or length of time in AIDS care
- Female respondents rate slightly higher on burnout scores
- Clinical supervision can have a key role in burnout protection
- A supportive model of supervision is most appropriate
- The development of informal links with practitioners in the same area of practice could help to reduce burnout
- Strategies to enhance feelings of personal achievement in practice can help to reduce burnout

Further research is required into:

- the relationship between staff gender and burnout in AIDS care;
- evaluation of different models of supervision in burnout protection;
- exploration of the role of informal support systems in burnout protection.

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